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Minimalist Medical Diplomacy – Do Engagements Achieve US National Strategy Global Health Security Objectives?

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Nathan T. Kellett, Maj, USAF

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Advisors: Lt Col Paul J. Hoffman and Lt Col Duane D. Gunn

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Contents

List of Acronyms and Abbreviations

AOR	**Area of Operations**
BCSO	**Bureau of Conflict and Stabilization Operations**
BPC	**Building Partnership Capacity**
BPRM	**Bureau of Population, Refugee and Migration**
CA	**Civil Affairs**
CCJO	**Capstone Concept for Joint Operations**
CENTCOM	**Central Command**
CME	**Civil-Military Engagement**
CMSE	**Civil-Military Support Elements**
COCOM	**Combatant Commands**
DART	**Disaster Assistance Response Team**
DoD	**Department of Defense**
DOS	**Department of State**
DR	**Foreign Disaster Relief**
DSG	**Defense Strategic Guidance**
FA	**Foreign Assistance**
FHA	**Foreign Humanitarian Assistance**
GCC	**Geographic Combatant Command**
GHE	**Global Health Engagement**
GHI	**Global Health Initiatives**
GHS	**Global Health Security**
HA	**Humanitarian Assistance**
HE	**Health Engagement**
HN	**Host Nation**
HSS	**Health Services Support**
ID&D	**Internal Defense and Development**

IOP	**Instruments of Power**
JIACG	**Joint Interagency Coordination Group**
JOA	**Joint Operational Area**
LNO	**Liaison Officer**
LOE	**Line of Effort**
Med FID	**Foreign Internal Defense – Medical**
MEDLOG	**Medical Logistics**
MEDRETE	**Medical Readiness Training Exercise**
MILPHAP	**Military Provincial Health Assistance Program**
MMD	**Minimalist Medical Diplomacy**
MOE	**Measures of Effectiveness**
MSF	**Medecins Sans Frontieres**
MSO	**Medical Stability Operations**
NMS	**National Military Strategy**
NSS	**National Security Strategy**
OCHA	**United Nations Office for the Coordination of Humanitarian Affairs**
OECD	**United States Office for Economic Co-Operation and Development**
OFDA	**Office of Foreign Disaster Assistance**
OHDCA	**Overseas Humanitarian, Disaster, and Civic Aid**
PACAF	**US Air Force Pacific Command**
PACOM	**US Pacific Command**
QDDR	**Quadrennial Diplomacy and Development Review**
QDR	**Quadrennial Defense Review**
RCMSE	**Regional Civil-Military Support Elements**
SDO	**Senior Defense Official**
SOCCENT	**Special Operations Command, Central**
SOCPAC	**Special Operations Command, Pacific**

SOF	**Special Operations Forces**
TSCP	**Theater Security Cooperation Plan**
TSOC	**Theater Special Operations Commands**
UAP	**Unified Action Partners**
USAF	**United States Air Force**
USG	**United States Government**
USSOCOM	**United States Special Operations Command**
WoG	**Whole of Government**

I. ABSTRACT

Given today's dynamic security, political and fiscal environment, there is an emphasis for the military to become more efficient with limited resources. To meet this objective, national strategic policy documents demand United States Government (USG) planners and strategists evaluate and identify balanced organizational resource capability synergies. Despite an emphasis towards limited cost and resource allocation, the USG still requires its agents, military and civilian, to advance the nation's strategic interests. To achieve this objective, the USG is working diligently to maintain commitments using its Instruments of Power (IoP) to strengthen alliances and partnerships through global engagements. Part of this strategy involves medical diplomacy, which has been leveraged to promote national interests since 1846. Today, medical diplomacy spans the continuum of war and requires synergistic collaboration between the military and Unified Action Partners (UAP) to ensure global stability promotes national interests and preserves security in the global commons. To examine the efficacy of Minimalist Medical Diplomacy (MMD) through Global Health Engagements (GHE) in stability operations, this paper will explore the historical means of US medical diplomacy strategies within the Pacific Command (PACOM) region and propose that MMD through GHE activities achieves the Global Health Security (GHS) objectives contained within the National Security Strategy (NSS).

II. INTRODUCTION

"Never doubt that a small group of thoughtful committed citizens can change the world; indeed, it's the only thing that has."[1]

Margaret Mead

Commitment to changing the world through international medical intervention at the individual, non-governmental and governmental levels permeates history. Following World War II, international medical intervention crystallized into the modern notion of medical diplomacy. Notwithstanding geopolitical hard power politics, the nascent concept of healthcare as a universal human right, with the needs of humanity superseding border considerations, is propelled by individual providers and non-governmental medical organizations, such as Armand Hammer, M.D. and Medecins Sans Frontieres (MSF).[2] In 2004 Secretary of Health and Human Services, Mr. Tommy G. Thompson, suggested medical diplomacy was, "the most exciting [and relevant] program to further America's causes around the world."[3] In his Boston Globe Op-Ed piece, "The Cure for Tyranny," Mr. Thompson suggested that medical diplomacy was the winning of the people's hearts and minds by exporting medical care, expertise and personnel in support of those who need it.[4] His altruistic position morphed into a growing US government consensus in the early 21st century that public health issues were not only universal, but posed a significant threat to national security.[5]

Few scholars and political elites question the relevance of global public health threats to national security and, many view medicine as a unique sub-set within US diplomacy. In the 2014 National Intelligence Estimate, global infectious disease remains the foremost health security threat worldwide, endangering US citizens at home and abroad; as well as, partner nations with whom the US has significant interests.[6] In President Obama's 2010 and 2015 National Security Strategies, global health prevention is specifically mentioned as an imperative requiring "the US [to] proactively invest in stronger societies and human welfare of states at risk

of conflict and violence."[7] Medical diplomacy is further promoted by the President's support for prevention through preemption which he outlines as the US "investing in the capable partners of the future….building [their] capacity to strengthen the foundations of our common security, and modernizing the US' capabilities to ensure [agility] in the face of change."[8] This policy position is further included in the Department of Defense's (DoD) National Military Strategy (NMS) and Quadrennial Defense Review (QDR). In the 2011 NMS, one-half of the Overseas Humanitarian, Disaster, and Civic Aid appropriations were ear marked for Health Services Support (HSS) operations/activities.[9] In addition, the QDR expanded biological threat reduction activities to include syndromic surveillance and response.[10] Furthermore, in 2013, the Secretary of Defense issued policy guidance defining GHE parameters and required Geographic Combatant Commanders (GCC) to outline how their security cooperation projects aligned to their Theater Security Cooperation Plans (TSCP).[11] As evidenced by these national security policy documents, the US endorses medical diplomacy and requires it strategically align to the NSS by, with, and through other US agencies; as well as, Non-Governmental (NGO) and International Governmental Organizations (IGO).[12] Today, medical diplomacy through GHE requires the US re-examine its military and inter-agency capabilities and prioritize the burgeoning demand for medical support within a chaotic geopolitical environment. Meeting these objectives requires a thorough examination of the types of US GHEs, as well as the efficacy of the programs to ensure policy and program synchronicity. To address current research deficits regarding alignment of GHE to NSS GHS objectives, this paper will explore the effectiveness of MMD Civil Military Engagements (CME) during Phase 0 and IV operations.

III. US Medical Diplomacy and Global Health Engagements

"The condition of infrastructure is often a barometer of whether a society will slip further into violence or make a peaceful transition out of the conflict cycle."
Donald F. Thompson

Official US medical diplomacy is achieved through civilian and military GHE programs that span the entire continuum of military and diplomatic operations. US civilian agency medical diplomacy programs are led by the Department of State (DOS) through USAID. In its 2010 Quadrennial Diplomacy and Development Review (QDDR), the DOS listed public health as one of the cornerstones of global civil affairs operations.[13] To achieve the operational goals of helping Host Nations (HN) make a peaceful transition to democracy requires a Whole-of Government (WoG) approach between the DOS's Chief of Missions and Country Teams, as well as its inter-agency, military, international and non-governmental organization partners.[14] Within the DoD, medical diplomacy programs are included within GCC's TSCP to shape US/HN relationships.[15] These programs are traditionally coordinated by the DOS and serve to augment US government civilian efforts in building self-sustaining HN health care systems.

GHE activities include Humanitarian Assistance and Foreign Disaster Relief (HA/DR), military exercises, building partner capacity through health infrastructure development projects, subject matter expertise exchanges and syndromic surveillance.[16] Traditional Health Service Support (HSS) operations fall under the umbrella of CME and include, but are not limited to: Medical Foreign Internal Defense (Med-FID), HA/DR and Medical Stability Operations (MSO). The following paragraphs provide a general overview of how and when these HSS CMEs are used.

Foreign Internal Defense (FID) is defined as the "participation by civilian and military agencies of a government in any of the action programs taken by another government or other

designated organization to free and protect its society from subversion, lawlessness, insurgency, terrorism, and other threats to their security."[17] It incorporates a full range of measures to promote growth and protection of the supported state from the aforementioned security threats.[18] In the 2014 QDR, Defense Secretary Hagel noted the "DoD will rebalance our counterterrorism efforts toward greater emphasis on building partnership capacity, especially in fragile states, while retaining robust capability for direct action."[19] Although security cooperation and FID engagements are proactively focused upon preventing instability and insecurity, the distinct difference between them is FID generally involves deployments of Special Operation Forces (SOF) to unstable and insecure environments, while security cooperation engagements occur in stable environments.[20] FID's genesis derives from America's history of international support, particularly following World War II, and focuses upon a HN's Internal Defense and Development (ID&D) through security cooperation, indirect and direct support and combat operations.[21] ID&D integrates security forces and civilian actions into a comprehensive effort.[22] Using balanced development, security, neutralization and mobilization as independent functions, ID&D synchronizes military and civilian forces to form a unity of effort that prevents or counters HN internal threats. The burden of coordination falls to the US Ambassador and Country Team working with the host nation, of which the Senior Defense Official serves as the DoD lead.[23]

ID&D operations rely implicitly upon CMEs to garner popular support for a HN government and afford it time to resolve grievances internally. US joint doctrine prescribes that "nation assistance is civil and military assistance (other than Foreign Humanitarian Assistance [FHA]) rendered to a nation by US forces within a nation's territory during peacetime, crises or emergencies, or wars based on mutually concluded agreements between the US and a HN."[24] Med-FID missions are but one of a number of CME ID&D missions and focuses upon balanced

development efforts through direct support operations. Med-FID, HA/DR, and MSO overlap within the overarching HN CME mission, however. Appreciating their differences facilitates an understanding of just how each program complements the other. Although Med-FID, HA/DR and MSO are conceptually national assistance activities, their differences are exemplified by intent and duration. Each program follows the notion of "prevention through preemption."

Med-FID operations tend to be smaller and shorter than traditional CMEs, such as MSO and HA/DR and serve as sentinel programs in support of other Civil Affairs (CA) activities within a restrictive environment (otherwise known as hostile Joint Operational Areas - JOA).[25&26] With the goal of protecting and insulating a HN from security threats, FID programs, typically staffed by SOF personnel, are leveraged by the DOS Country Teams to serve as intelligence gathering assets that assist with needs assessments for the facilitation and coordination of larger CME programs throughout the continuum of military operations.[27] Traditionally, Med-FID is leveraged during the Phase 0 Shaping Operations where the JOA is unstable and civilian security may not be assured. HA/DR consists of, "US military and civil activities outside the US and its territories to directly relieve or reduce human suffering, disease, hunger and privation."[28]

HA/DR activities are conducted by conventional forces to reduce human suffering, disease, hunger and/or privation while affording a HN government time to take ownership of the relief and support operations. DoD support missions to these activities typically include dislocated civilian support, security operations and foreign consequence management. DoD involvement in these activities is limited in scope and duration in accordance with international laws and conventions and may be leveraged throughout the continuum of military operations, but most often utilized during Phase IV Stability and Reconstruction (S&R) operations. [29]

In accordance with Field Manual (FM) 3-07, stability tasks are part of every operation and fall within five specific tasks: (1) establish civil security, (2) establish civil control, (3) restore essential services, (4) support to governance, and (5) support to economic and infrastructure development.[30] MSOs are also conducted by conventional forces, but may be leveraged by SOF in non-permissive security environments to "supporting efforts to establish or restore medical support necessary to sustain the population until local civil services are restored; assessments of the civilian medical and public health systems such as infrastructure, medical staff, training and education, MEDLOG, public health programs, and promoting and enhancing the HN medical infrastructure."[31] MSOs are a part of and/or fulfill FM 3-07 stability tasks steps 3 and 5 directly and enable HN governments to regain governance capacity by fulfilling basic services requirement gaps. MSO's are usually leveraged during Phase IV Stability and Reconstruction (S&R) operations and may overlap with HA/DR engagements.

IV. Historical Minimalist Medical Diplomacy Experiences and Challenges

Historical precedents for MMD permeate US military history from the rebuilding of the Philippine public health infrastructure following Commodore Dewey's naval victory over the Spanish squadron in Manila bay in 1898 to current COIN operations in Afghanistan.[32] Traditional MMD was predicated upon benevolence with de minimis, or basic and direct care, as the principal form of HA.[33] Humanitarian aid was a source of US national prestige and served as a pacification instrument for US diplomacy. During the Philippine insurrection lead by Emilio Aguinaldo from 1898 – 1899, the US identified pacification as a key military strategy to quell insurrection with public health serving as a principal developmental pillar.[34] Pacification through medical diplomacy evolved into a formal program during the Vietnam War, where the DOS deployed civilian medical providers as part of the Provincial Health Assistance Program

(PHAP) to train Vietnamese medical providers and technicians. As violence escalated in 1965, the Secretary of Defense directed the military medical service to support and, in some instances, replace PHAP teams. The Military Provincial Health Assistance Program (MILPHAP) consisted of joint DOS and military providers and focused upon developing hospital infrastructure and supply chain management activities as well as medical education and training and public health surveillance.[35] Coupled with this program was the precursor to today's Medical Readiness Training Exercise MEDRETE), GHE and infrastructure modernization activities which consisted of special force personnel focused upon mobile outpatient care and local health worker training.[36] The Vietnam War MEDRETE, GHE and infrastructure modernization missions were heralded as a success and continue today as practical models for medical diplomacy leveraging heterogeneous teams of SOF and conventional forces in support of the GCC's TSCP.

Notwithstanding the successes of MILPHAP, current MMD has achieved mixed results.[37] In a 2007 study of post-conflict HA/MSO reconstruction efforts in the Japanese, Kosovo, Iraq and Afghanistan health systems, RAND identified policy and programmatic incongruities in the application of minimalist medical diplomacy.[38] Although the Japanese healthcare system reconstruction was accomplished through the support of US military medical personnel by instituting reforms in disease prevention, health system reorganization, and medical education, these same successes were not transferrable in Kosovo, Iraq and Afghanistan. Qualitative analysis of these theater engagements concluded either partial or complete failure of mission objectives resulting from misalignments in acquisition, human capital management, and coordination with IGO and NGOs.[39]

Despite recent successes of MMD during the 2004 Haiti and 2010 Pakistan HA/DR operations, US medical diplomacy continues to be disproportionate, fragmented and

administratively mismanaged. During low intensity conflicts, "which consist of a wide range of military activities where military capabilities are used for purposes other than large-scale combat operations usually associated with war," these issues are compounded by uncertain planning, fragmented command and control rapidly changing priorities and ill-defined rules of engagement.[40] Throughout these engagements, minimalist medical diplomacy has focused disproportionately upon providing direct patient care services to specific populations for limited periods of time and left the larger secondary focus of public health infrastructure development unresolved.[41] Disproportionality examples include Med-FID operations, which oftentimes focus upon village elders and their families for intelligence rather than health surveillance. Also, HA/DR missions limited scope to crisis response and limited contingency operations produce disproportionate care to a limited JOA that may undermine existing HN health service infrastructure and/or inter-agency/non-governmental organization health programs.[42] These missions may further create a capacity vacuum once the mission is completed, unless planners anticipate ongoing mission requirements.[43] Finally, MSOs are typically not limited by durational constraints, yet may be misaligned with overarching DOS CA operation objectives. During shaping operations, military and civil MSOs may not be synchronized due to competing requirements. In fact, military personnel oftentimes create dependencies rather than support when they provide disproportionate direct care to the populace and lose sight of the strategic picture of the DOS MSO program.[44] An example of this type of situation includes heroic surgical measures to save severely wounded children in war zones, wherein the HN medical infrastructure cannot support follow-up care.

As evidenced in the disproportionate care examples, a major factor underlying these operational incongruities stems from administrative fragmentation. National Security

Presidential Directive 44 designates the DOS as the lead agency within the USG to "promote the security of the US through improved coordination, planning, and implementation of Recovery and Stability assistance for foreign states and regions at risk of, in, or in transition from conflict and civil strife."[45] HA/DR missions are further authorized by the National Command Authority at the behest of a HN Ambassador of the US Secretary of State.[46]

In 2011, the DOS created and charged the Bureau of Conflict and Stabilization Operations (BCSO) with advancing U.S. national security by working with partners to break cycles of violent conflict, strengthen civilian security, and mitigate crises in priority countries.[47] The BCSO supports the DOS by providing analysis, strategic planning, and on-the-ground operational guidance, yet does not have funding or governance authority.[48] The BCSO creates a strategic ad-hoc command and control administration, and leaves inadequate oversight and budgetary support for JOA military, inter-governmental and non-governmental agency planning and coordination. Military GCCs fill the strategic gap and focus medical diplomacy prioritization upon JOA mission objectives as determined by threat intelligence, Patient-At-Risk (PAR) estimates, duration of the operation, theater patient movement policy, available lift, MEDLOG capabilities, and hospitalization requirements.[49] Furthermore, DoD Directive 3000.5 outlines, "stability operations are a core US military mission that the Department of Defense shall be prepared to conduct and support.[50] Since most HA/DR and Med-FID operations occur in restrictive JOAs, the military has historically acted as the lead federal agent until the environment is secure. This doctrinal role reversal creates incongruities in operational prioritization despite the DoD and DOS' attempt to resolve strategic planning coordination through the Joint Interagency Coordination Group (JIACG) as well as tactically through the assignment of liaison officers (LNO) within the operational units of the DOS and DoD.

Finally, the doctrinally supported/supporting role reversal between the DOS and DoD in medical diplomacy missions appears to be approved by Congress through its appropriations legislation. According to the Defense Security Cooperation Agency FY14 Budget Estimate, the military's Overseas Humanitarian, Disaster Relief and Civic Aid totals $109 million while the DOS and USAID FY14 budget for similar programs totals $47 million.[51] Coupled with these formal budget projections are the other interagency transaction authorities, which may support Med-FID, including The Foreign Assistance, Economy and Arms Export Control Acts.[52] This deep funding pool creates a strong incentive to further posture the DoD as the lead federal agent in medical diplomacy. Furthermore, as anecdotal stories abound from Operation Iraqi Freedom S&R operations, the DOS continues to be slow to allocate funds while their LNOs, working in conjunction with DoD operational leaders/planners, attempt to circumvent DOS administrative gridlock to achieve the very mission success agreed upon by DoD and DOS members at the JIACG.[53]

Without a well-supported cabinet level position for US Restoration & Stability operations, the likelihood of role reversal and mission objective incongruities between the DOS and DoD will continue during US medical diplomacy missions. Furthermore the lack of mission authority undermines the credibility and capabilities of operational inter-agency LNOs. Until LNOs are able to reach back to their parent organizations to produce actionable responses to medical diplomacy requirements bureaucratic morass will perpetuate. Finally, until the DoD and DOS examine the compatibility of their respective agency doctrine and capabilities to national security policy, medical diplomacy operations will be operationally haphazard and may undermine national security grand strategy objectives.

Notwithstanding the need to address the strategic administrative mismanagement of US medical diplomacy there is no question that US medical diplomacy may be leveraged to reduce US national security threats. With the understanding that disease, natural disasters and humanitarian crises are transnational threats that may be neutralized using a WoG approach that builds a HN partner's capacity through security cooperation engagements, minimalist medical diplomacy doctrine and execution strategies require a re-evaluation. In "Sustaining US Global Leadership: Priorities for 21st Century Defense," the DoD prescribes the institutionalization of minimalist stabilization, described as an innovative, low-cost small footprint approach to Phase 0 and IV operations.[54] This strategy, though found by RAND to not contribute significantly to success in overall HN LIC objectives, may be beneficial to connecting medical diplomacy objectives to strategic national security objectives.[55]

Minimalist stabilization combines military and civilian activities to "influence the political authority structure of a state in or recovering from violent conflict."[56] Despite the traditional FID focus upon counter-insurgency, Med-FID operations tend to be classified as CMEs that may be uniquely tailored to execute minimalist stabilization objectives with UAP. In accordance with the 2012 Defense Strategic Guidance (DSG), Med-FID CME activities rely upon exercises (MEDRETE), rotational presence (Global Health Engagements) and advisory capabilities.[57] CMEs bridge the interagency gap and assess HN capacity in the areas of governance, economic development and security. Med-FID activities are included with active component Civil Affairs (CA) teams and coordinate by the Theater Special Operations Commands (TSOCs). Under the auspices of the United States Special Operations Command (USSOCOM) CME program, the CA teams address Civil-Military capability and information gaps among GCCs, TSOCs, and UAPs at the operational and tactical levels.

The military-civilian gap in the post 9/11 era may be closing due to the inculcation of minimalist stabilization strategy in joint and UAP doctrine. Joint Publication 1 defines interagency coordination as collaboration between USG agencies and departments to achieve an objective.[58] In addition to JP 1, the CME program also executes through Title 10 Section 167 authority, which assigns the USSOCOM Commander to develop strategy, doctrine and tactics that complement the 2012 DSG and Capstone Concept for Joint Operations (CCJO). In ADM. McCraven's USSOCOM 2020 vision, the global SOF network is suited to execute the guidance of the DSG and CCJO in support of GCCs and the DOS Chief of Mission.[59] This guidance affords Civil-Military Support Elements (CMSE) the ability to perform Med-FID missions that reduces the military signature of traditional MSO missions and allows for better integration with embassy, HN and UAP medical diplomacy activities, thereby improving HN management of medical HA/DR and MSOs. Furthermore, Regional CMSE (RCMSE) afford TSOC Commanders with a dedicated capability to plan, coordinate and execute theater-wide CME and will include UAP fusion to ensure adequate inter-agency reach-back/support.

Civil Affairs (CA) operations seek to enhance UAP and military relationships, require coordination through the WoG, and, within the HN, include specialty-trained professional forces (i.e. medical providers) to enhance the conduct of CMEs.[60] The scalability and low-cost of CME affords the military and UAPs with continuous communication and coordination of effort to meet US medical diplomacy mission objectives that align to US national interests. Since 1846, the US has demonstrated the necessity for planning and executing Civil-Military Operations as part of its political-military campaign strategy.[61] The following examples of minimalist stabilization CME activities in Bangladesh and Jordan will be used to discuss the potential effectiveness of CME medical diplomacy.

In 2007, Cyclone Sidr devastated southern Bangladesh, leaving 4,000 people dead, three million displaced, and $2.3 billion in economic damages.[62] Following a disaster declaration, the US government infused Bangladesh with $19 million in assistance and deployed two USAID Disaster Assistance Response Teams (DART) and the *U.S.S. Kearsarge*. In 2008, the US activated CMSE-Bangladesh to augment the USAID DART. The team consisted of SOF members who were previously active within the country and assisted the DOS Country Team and USAID by evaluating the Bangladesh government's disaster response capacity, identifying HN civil infrastructure vulnerabilities and coordinating immediate HA/DR projects. They further evaluated existing UAP programs and provided intelligence reports on rehabilitation and reconstruction programs. Their efforts produced a Common Operating Picture to refine long-term plan objectives and initiated short-term program solutions to bolster civil support and confidence in Bangladesh's government. Using Overseas Humanitarian, Disaster, and Civic Aid (OHDCA) funding that aligned to Title 12 of the FY08 National Defense Authorization Act, the DoD funded programs through the DOS to extend and enhance authority for stabilization assistance.[63]

In 2012, the US Jordanian Ambassador, Stuart E. Jones, invited Special Operations Command Central (SOCCENT) to integrate a CMSE into his Embassy team.[64] CMSE-Jordan conducted an analysis of the country's civil vulnerabilities, particularly assessing its public service capacity for handling displaced populations. As the conflict in Syria continued throughout 2012, 140,000 Syrian refugees entered Jordan sparking the United Nations High Commission for Refugees to conclude that the Jordanian government was under enormous strain and required international support. Working in conjunction with the DOS Bureau of Population, Refugee and Migration (BPRM), CMSE-Jordan developed a COP for the DOS Country Team,

which identified gaps in the Jordanian government's ability to support the refugee population and incumbent population in the city of Mafraq. The refugee conditions presented serious concern regarding the government's ability to provide adequate food, water, sanitation and medical support and prompted SOCCENT and CENTCOM to advocate for increasing OHDACA funds to support long-term and short-term civil support programs. Through CMSE-Jordan's collaboration US interagencies, international relief organizations, non-governmental organizations and the Jordanian Ministry of Health, the US government was able to create a persistent nexus between the two countries and nest long-term strategic and development programs within a UAP.[65]

V. Methods

Broadening persistent engagement through minimalist medical diplomacy activities such as Med-FID CMEs should improve UAP and HN collaboration, harmonize long- and short-term program objectives, and reduces disproportionate and fragmented US responses. Yet, there has not been an assessment of whether these engagements support strategic initiatives or facilitate the alignment of role appropriations for civil and military forces. Although GCCs and UAPs use Measures of Effectiveness (MOE), the models are disparate and focus upon theater and country specific operational objectives instead of strategic goals. To address this deficit, an empirically based study should be conducted to determine the effectiveness of MMD CMEs during Phase 0 (Shaping) and Phase IV (Stability and Reconstruction) operations to meet NSS GHS objectives.

Using a mixed method approach derived from a qualitative meta-analysis of peer-review literature and a quantitative evaluation of the types of US health engagements derived from PACOM, SOCPAC and PACAF annual reports, PACAF Health Engagement Priorities and USAID Office of Disaster Assistance (OFDA) Global Health Initiative (GHI) priorities, the

paper explores whether US MMD activities fulfill NSS objectives. The study adopts a concurrent embedded strategy mixed methods approach, within which qualitative and quantitative data is collected simultaneously to provide the reviewer with a composite assessment of the problem.[66] The quantitative element of the study compares DoD GHE activities to DOS GHI activities from 2000 – 2013, while the qualitative element compares GHE and GHI activities to the 2000 and 2015 NSS GHS objectives. Benefits to using a mixed method approach include focusing the study beyond nascent US Building Partnership Capacity (BPC) strategies to examine, specifically, the impact of US GHE activities in achieving GHS objectives. Furthermore, the approach allows the reviewer to understand the national strategy premise from which health engagements are employed.

The US conducts a variety of GHE/GHI activities around the world, with a comprehensive review of these activities beyond the scope of this study. However, to elicit discussion about the efficacy of these activities, this study focuses upon military and civilian GHE activities during security shaping operations. Following an analysis of Combatant Command (COCOM) historical activities during Phase 0, Theater Security Shaping Operations, the Pacific Command (PACOM) was selected as the predicate case study source due to its high incidence rate of GHE/GHI activities as compared to other COCOM AORs. Using global health statistics and GHS reports from USAID, the World Health Organization and World Economic Forum, the selection criteria of case study countries includes the following Tier I (industrialized) and II (developing) countries within the PACOM AOR: Japan, Philippines, Indonesia, Vietnam, Cambodia, Laos, Myanmar, Bangladesh, and Sri Lanka.

Data collection for the study included GHE/GHI fiscal appropriations and activities for comparison of funding and activity priorities to the NSS GHS strategy. Global humanitarian

appropriations for the period 2000 – 2013 were collected from the US Organization for Economic-Cooperation and Development for comparison to PACOM AOR country budgets for USAID Office of Foreign Disaster Assistance (OFDA) and the DoD (appropriations data for the DoD only includes information from 2011 – 2013). Appropriations data was further refined by country and health engagement type (Disaster Readiness, Malaria, Humanitarian Assistance [SMEE, Medical Trainings and Exercises, Health Development Meetings, and Senior Leader Exchanges], Public Health, Health General [Specialty engagements such as: Maternal and Child Health and Veterinary exchanges], and Pandemic Flu & Other Emerging Threats).

Historical GHI/GHE activities were collected from USAID/OFDA for the period 2000 – 2013 and compared to DoD/GHE activities for the period January, 2013 – June, 2014. The activities were classified based upon type of engagement or Line of Effort (LOE) for each country. USAID LOE activities included: Capacity Building, Health Governance, Direct Care, Public Health, Maternal & Child, and Pandemic Flu Prevention. DoD LOE activities included: Capacity Building [Pacific Partnership, Blood Program and Veterinary Engagements], Health Governance [Senior Leader Visits], Trainings and Exercises [Field Training Exercises, Subject Matter Expert Exchanges, First Responder Training, Workshop/Seminar/Meetings], Disaster Response Exercise and Exchanges [Public Health, Emerging Disease and Pandemic Flu Prevention].

In addition, prospective DoD GHE activities were collected from PACAF for the period 2014 – 2019 and compared to the historical USAID/OFDA and DoD GHI/GHE activities. PACAF prospective GHE activities included: HA/DR Coordination [Field Training Exercises, Subject Matter Expert Exchanges, First Responder Training, Workshop/Seminar/Meetings], Patient Movement [Fixed and Rotary Wing Evacuation), Expeditionary Medical Support [Pacific

Partnership, Blood Program, Veterinary Engagements, First Responder Training, and Workshop/Seminar/Meetings], Infrastructure Development, Foreign Military Sales [military equipment sales] and Biosurveillance [Public Health, Emerging Disease and Pandemic Flu Prevention].

Finally, a literature review of US historical GHE and HA activities from 2000 – 2013 compared findings and recommendations to historical and prospective USAID/DoD GHI/GHE activities, as well as the 2010 and 2015 NSS GHS objectives. Initial GHE/HA data collection was conducted and included queries with the PACOM, SOCPAC and PACAF J5 (Strategic Plans) and J7 (USPACOM) offices. Research queries focused upon "5-Year Country Plans," "Annual Reports," and "Operational and Exercise After-Action Reports" (AAR). Each report and/or country plan was then reviewed to identify MMD, GHE and other related medical diplomacy activity factors/elements related to BPC programs during Civil-Military Engagements (CME) and MSOs. Additionally, to address timeline or operational gaps in COCOM historical products, interviews with COCOM and MAJCOM Historians were conducted. Data related to MMD and GHE activities were extrapolated from these reports and interviews for each previously identified Tier I and II country and compiled in USAID and DoD support activity tables. In addition, the author completed MEDLINE®, JSTOR, ProQuest and EBSCOHost database searches as well as the Air Force Historical Agency repository from October, 2014 – April, 2015 to retrieve articles related to US health engagement activities for the period 2000 - 2013. Additionally, Air Force and Joint Force policy searches were completed to include doctrinal guidance and references for the employment of health engagement activities to achieve US NSS objectives. Search terms included: "Medical Diplomacy," "Building Partnership Capacity," "Global Health Engagements," "Foreign Internal Defense," "Civil-Military

Engagements," "Minimalist Diplomacy," "Minimalists Medical Diplomacy," "Health Diplomacy," and "Minimalist Health Diplomacy." Journal articles were retrieved from diverse fields of study; including, political science, organizational behavior, project management, and health services research. Furthermore, the reference lists of each article were reviewed in detail to find additional sources. The reviewer independently examined each article and document in full text (n = 143: 112 journal articles and an additional 31 Federal documents and reports), evaluated the article's relevance to the topic and determined 58 for inclusion and 85 for exclusion. Health engagement activity recommendations for improving GHE/GHI were then classified (i.e.: Joint Education and Training, Unified Strategic Vision, Unified Organization, Measures of Effectiveness Standardization, Expanded US/HN Military Partnerships, Expanded US/HN PME, Expanding HN/HN Military Partnerships, Improve HN and US Civilian/Military Communication, and Establish/Codify Military and Civilian End State Objectives) for the purpose of comparing activity focus and recommendations to NSS global health security objectives. Finally, the resulting qualitative case studies and quantitative reports were compared to identify the types of US MMD GHE activities and assess civil-military program gaps and/or redundancies to provide the reviewer with a broad perspective of theoretical and applied MMD GHE strategy.

VI. Limitations and Challenges

There are a number of limitations to this study. Strategic and operational health engagement strategies include a variety of programs, authorities, funding sources and multi-modal organizational participation making the identification and attribution or correlation of tactical level activities to strategic consequences difficult. Furthermore, records about these activities are incomplete and compiled by a number of resources. Compounding this issue is the

fact that data is not stored uniformly by a specific command or office with direct responsibility of the activity or program, which makes retrieval challenging. Moreover, data classification restrictions confine the analysis in the paper to authorized information available within the public domain.

Notwithstanding the source complexity, GHE activities are applied to variety of objectives and purposes. These actives are oftentimes associated with other BPC activities simultaneously as part of a national infrastructure or military development program. Adding to the potential for causal conflation are Interagency and NGO health engagement activities in association with military GHE and programs. Furthermore, researchers must decide whether there is relevance in omitting potential activities and/or including revised/amended activities. Will the modified and/or omitted activity undermine other US and HN BPC programs?

Codification of available quantitative data is convoluted by historical GHE classifications and requires naming convention normalization for interpretation. In addition, country comparisons, though useful in the assessment of GHE/GHI global applications, are not equitable given US NSS regional objectives. The researcher will attempt to address the analysis inequities and provide the reviewer with a cogent explanation to refute the study's confounding variables.[67]

VII. Results

According to the United Nations Office for the Coordination of Human Affairs (OCHA) and the United States Office for Economic Co-Operation and Development (OECD), inter-agency appeals for humanitarian crisis assistance typically target 60-70 million people each year, with funding requirements averaging over US$10 billion. In the past decade, the number of people requiring international Humanitarian Assistance and the cost of helping them has increased

significantly. Several global trends are attributed to the increased risk of major crises, as well as their complexity including, but not limited to climate change, population growth, rapid and unplanned urbanization, and food and water insecurity. In addition, annual recurrent crises appear to be increasing due to greater awareness and reporting capabilities. Recurrent crises plague the PACOM AOR, despite regional developmental gains and increased aid. The increased awareness and needs throughout the PACOM AOR have affected both Industrial (Tier I) and Developing (Tier II) countries by undermining government operational and financial capacity to respond to and support humanitarian response. This deficit has caused donor and recipient countries to transform their humanitarian preparedness and response strategies. Although there have been dramatic advancements in syndromic and environmental surveillance, humanitarian aid remains overwhelmingly focused upon response, with development assistance failing to target the most vulnerable populations. To address this deficit, government, donors and humanitarian organizations are moving to synergize humanitarian and development actors and programs to target aid for resilience and improve crisis risk management.[68]

Although inter-agency appeals provide one indication of the scale of humanitarian need, there is no comprehensive global picture. Nonetheless, according to US ODECA, the Foreign Assistance (FA) (including social infrastructure and humanitarian aid) apportioned to the PACOM Tier I and II countries in this report (Japan, Philippines, Indonesia, Vietnam, Cambodia, Laos, Myanmar (Burma), Bangladesh and Sri Lanka) totaled US$21,623 Billion (Appendix A). Myanmar (Burma) and Vietnam were the leading benefactors of global HA receiving approximately US$7.6 and US$4.8 Million respectively. The preponderance of assistance to these countries included social infrastructure development, particularly in the health and public work sectors.[69]

To better understand US FA, researchers should begin with an appreciation of budgeting and appropriations strategies. Financial apportionments and expenditures afford insight into the economic behaviors of FA donors, in particular civil and military governmental sectors. The ForeignAssistance.gov website, initiated by the DOS and USAID under the policy guidance of the National Security Council, outlines USG FA expenditures and investments. The source data derives from FA budget planning, obligation, spending and transaction data for USG agencies that are currently reporting (i.e. USAID, DOS, Millennium Challenge Corporation, Treasury, DoD, Peace Corps, Inter-American Foundation, Department of Health and Human Services, and Department of Agriculture).[70] For the period 2011 – 2013, USAID obligated a total of US$1,269,535,480 and spent US$1,283,956,144; while the DoD obligated a total of US$56,373,656 and spent US$17,538,877 for the PACOM AOR research focus of this study (Appendix B). The preponderance of USAID funding focused upon Disaster Readiness (including response and preparedness) and syndromic surveillance and prevention activities, with the Philippines, Bangladesh and Myanmar receiving the largest bolus of funding during these years. DoD funding focused primarily on Disaster Readiness and cursorily upon Humanitarian Assistance (relief operations) and Public Health (Syndromic Surveillance and prevention). The largest amount of funding was awarded to Cambodia and Bangladesh, while the Philippines received the largest amount of Humanitarian Assistance. DoD Public Health activities were strictly targeted to Vietnam and the Philippines. The DoD did not apportion any funding for Pandemic Flu & Other Emerging Threats, nor did it focus upon Malaria prevention and Health General activities. Conversely, USAID appropriations targeted Disaster Readiness, Malaria, Public Health and Pandemic Flu and Emerging Threat activities while abstaining from Humanitarian Assistance and Health General Activities (Appendix C). Although USAID is

recorded as participating in Humanitarian Assistance activities during this period in case studies, the preponderance of funding to support their engagements derived from other donors and resources.[71] The FY15 USAID budget for HA includes US$4.5 Billion for protection assistance and solutions, US$149.8 Million for Disaster Readiness and US$30.5Million for Migration Management.[72] Each of these programs progress the DOS and USAID's Joint Strategic Goals to effectively manage transitions in frontline states and promote disaster mitigation and Humanitarian Assistance.[73] Within the PACOM AOR study countries the HA budget totals US$849,500,000 and reflects increased apportionments for Bangladesh, Indonesia and the Philippines. In addition, the FY15 DoD/OHDCA budget for HA includes US$100Million for Humanitarian Mine Action, Foreign Disaster Relief and Humanitarian Assistance programs. Of the US$100Million HA total, PACOM is anticipated to receive US$41.2Million (US$5.841 for Humanitarian Mine Action, US$15Million for Foreign Disaster Relief, and US$79.159Million for Humanitarian Assistance). The DoD is expected to complete a total of 115 HA projects in PACOM, with activities related to transportation, excess property and other targeted assistance preparedness and mitigation in countries deemed strategically relevant to the foreign policy and national security objectives. Foreign Disaster Relief is sequestered for catastrophic environmental and man-made events throughout the PACOM AOR. Finally, PACOM Humanitarian Mine Action programs are to be focused upon Cambodia, Thailand and Mongolia (for a breakdown of FY15 USAID and DoD budgets see Appendix D).[74]

In addition to FA donor economic behavioral analysis, researchers should also examine civil and military GHE activities to appreciate Theater Security Planning and Strategy. Using source data from USAID/OFDA for the period 2000 – 2013 as well as PACOM Annual Reports and Global Health Security Briefs for January, 2013 – June, 2014, the following paragraphs compare

civil-military GHE within the PACOM AOR. From 2000 – 2013, USAID/OFDA awarded a total of 273 FA projects to the PACOM AOR study countries, 60 of which were designated as GHI. Although the Philippines and Bangladesh garnered the majority of total FA and GHI projects; statistically, Cambodia and Myanmar received greater focus with regards to GHI programing activities (Appendix E). With regard to the type GHI projects, the preponderance of awards went towards Capacity Building and Public Health (Appendix F). Capacity Building projects were directed towards clinic infrastructure sustainment, renovation and/or modernization; while Public Health projects focused heavily upon vaccination and preventative health programs.[75]

From 2013 – 2014, DoD GHE activities have focused upon building partnership capacity and resiliency. Of the 148 PACOM AOR GHE projects, the DoD has concentrated efforts upon military to military, as well as HN civilian and military Subject Matter Expert and Leadership Exchanges. Relying upon field trainings, disaster response exercises and professional colloquiums and meetings, DoD planners are shifting the historical GHE focus from direct care engagements (i.e. MEDCAPS, ENCAPS and VETCAPS) to a WoG approach designed to build partner capacity through interoperability that cut across Theater Cooperation Plan sub-campaigns and contribute to national and regional security and stability. During the 2013 – 2014 period, the preponderance of DoD GHE activities within the PACOM AOR study countries received capacity building support, participated in military and civilian Disaster Preparedness trainings and field exercises and/or participated or convened meetings/colloquiums related to health system governance. Bangladesh and Vietnam appeared to be the principal focus of the PACOM SG, garnering the preponderance of project and program activities (Appendix G).[76&77]

The DoD's operational and strategic Theater Security GHE strategy shift is further apparent in the USAF's prospective priorities and LOEs. In PACAF's Health Engagement Strategic Plans for the PACOM AOR countries considered in this study from 2014 – 2019, it is clear the locus of engagements is centered upon Disaster Relief Coordination, Patient Movement and Expeditionary Medical Support. As proscribed by PACOM, each of these LOEs demand direct partnership engagement for the purpose of building partner resiliency and capability. Relying heavily upon Trainings and Exercises, as well as regional meetings, Subject Matter Expert Engagements not only drive development support and partner resiliency; but also afford US operational and strategic leaders with a better understanding of interoperability gaps to improve disaster planning coordination and response. Engagement data suggests PACAF's GHE partnership development activity is focused towards Indonesia, Bangladesh, Myanmar and the Philippines. In addition, PACAF's GHE bio-surveillance development support activities is focused upon Laos and Bangladesh (See Appendix H for a visual description of the USAF LOE and activities by study country).[78]

VIII. Literature Review Recommendations and Discussion

US GHE, including HA/DR and MMD activities, has evolved since 2000 for the DoD, DOS and USAID. In 2000, US relief aid totaled US$1.2Billion, almost a third of all global Humanitarian Assistance.[79] Following a decade of humanitarian advocacy where the US leveraged assistance aid to enact political change, the attack on US soil on September 22, 2011 was seen by many policy elites and analysts as a catalyst for greater military involvement in humanitarian advocacy, not unlike historical precedents for such activity as found during the Cold War.[80] DoD and USAID HA budgets grew by approximately 60% between 2000 and 2001, with an increased focus in soft security wherein the US combined counterterrorism with HA to

stabilize fragile (developing states), reward allies and legitimize military interventions. .[81&82] Yet, pressures stemming from the 2010 financial crisis, as well as international and US domestic demand for resolution to US involvement in Overseas Contingency Operations caused USAID and DoD to reconsider unilateral HA based upon political conditionality for global coordination predicated upon neutral and impartial inter-dependence.

Throughout the first decade of the 21st Century, historical agency policy and strategy shifts, as well as operational GHE application, generated significant interest from policy think tanks, academicians and historians, as well as governmental policy analysts who generated a ponderous amount of performance research. Using research methodologies, such as case studies and meta-analyses, analysts offered recommendations ranging from reformations in national and regional strategy, as well as US agency ROEs, development support strategies and operations, and training. Notwithstanding potential political, social, academic and/or economic research agendas, the objective analysis contained in the every study, report and/or policy brief focused upon improving the delivery and efficacy of GHE (including HA, DR and MMD) to US partners throughout the global commons. Of particular interest to this study were the recommendations calling for improved inter-dependence or "jointness" between Non-Governmental Organizations (NGO), International Governmental Organizations (IGO), US and partner military and civilian agencies. To achieve this synergy, the articles identified four recommendation themes: Clarify Roles and Responsibilities, Consolidate Organizational Structures, Standardize Performance Measures, and Combine Education and Training Curricula and Enterprises.

Using the inclusion criteria outlined in the methods section of this study, what becomes more illuminating to reviewers is the policy wonks' interpretation of the recommendation themes. An overwhelming number of the articles proposed reformations to US agency roles and

responsibilities, organizational structures and performance measures. Particularly, the articles advocated US agencies should partner under a unified strategic vision of GHE that codifies military and civilian end-state strategies both domestically and internationally. To achieve a unified GHE vision, a majority of authors proposed a consolidation of organizational structures at the strategic and operational levels. A second order effect of such organizational transformation would also afford the USG the ability to improve and/or streamline strategy, activity, performance measurement and communication. Finally, many of the articles proposed US agencies participate in and/or consolidate training enterprises and opportunities. Specifically, the articles proposed improved relationships between US agencies, as well as NGO and IGOs are achieved by leveraging and/or combining inter-organizational training enterprises. Moreover, several articles encouraged US agency participation as brokers for HN military – military and civilian – military partnerships (Appendix I).

Comparing this study's literature review recommendations to US GHE historical and current budgets and activities presents an opportunity to examine how US strategists achieve US NSS GHS objectives. In 2010 and 2015, the US NSS GHS strategy was defined as an agenda to accelerate progress for the prevention of emerging infectious diseases and the promotion of GHS as an international security priority. In partnership with other nations, international organizations and public and private stakeholders, the GHS agenda is achieved through nine objectives (prevention of antimicrobial drug resistant organisms and emerging zoonotic diseases, promotion of national biosafety and biosecurity systems, reducing infectious disease outbreaks, strengthening and linking biosurveillance networks, normalizing reporting and sample sharing, developing novel diagnostic and strengthening laboratory systems, developing interconnected Emergency Operations Centers, and improving global access to medical and non-medical

countermeasures during health emergencies).[83] The 2010 US NSS translated GHS into countering biological threats, focusing solely upon detection and prevention; while the 2015 NSS expanded GHS to include response through an interdependent global network of Emergency Operations Centers.[84&85] Moreover, the 2015 NSS GHS agenda highlighted the US's role as the leader in GHS highlighting the US's responsibility to partner with international public and private governmental and non-governmental agencies in ensuring the detection, prevention and timely response to emerging diseases and health catastrophes.[86]

In 2013, USAID's Health and HA budgets totaled US$5,39 Billion and US$8.81 Billion respectively, while the DoD's HA budget totaled US$342.5Million. Although USAID and DoD historical GHE activity data demonstrated some program redundancies during this period with regards to capacity development, the data also illustrated improvements in program coordination, particularly disaster relief response, public health and syndromic surveillance. Moreover, there appears to be improved strategic and operational coordination of HA through GHE in restrictive environments, such as Myanmar, wherein USAID leverages NGOs to build upon the global GHS campaign, while supported by US military for mobility requirements during DR and augmentation of Subject Matter Experts during GHE activities.

As USAID, DOS and DoD improve the transparency of their HA and GHS strategies, the clarification of roles and responsibilities will become easier to delineate. What should be expected from this clarification is that the DoD will assume a greater MMD posture within the US GHS agenda, but remain vital to the realization of the US NSS GHS strategy. Furthermore, organizational transparencies are combining disparate programs and activities thereby promoting the unification of a US strategic and operational HA and GHE strategy. This transformation has become ubiquitous in Subject Matter Expert Exchanges, as well as training enterprises and

activities. The Civil-Military co-op within the COCOMs have consolidated not only strategy but resources to improve global coordination and demand response.

Notwithstanding these advances, gaps remain in HA/GHE activities. Specifically, organizational consolidations have yet to be achieved due to nascent organizational sectarianism, especially during fiscally austere years. Many organizations are reticent to change, especially if it appears to undermine their budgets. Yet, organizational consolidation should continue to be explored as GHE roles and responsibilities become more defined to improve response and programmatic synergies. Additionally, communication deficits remain, particularly in terms of command and control as well as performance improvements measures. Despite GHS agenda focus to improve DR global interconnectedness, not all governments, and/or public or private organizations have the capacity to meet the infrastructure and manning requirements associated with Emergency Operations Centers. To realize this GHS agenda objective will require further evaluation of international organizational consolidation and partnerships. Finally, measures of performance remain disparate. There are no standardized evaluation criteria for GHE activities. In fact, within the USG, civilian and military agencies maintain discordant evaluations tools, methods and databases. The divergence of evaluation methods and tools creates inconsistency in national and international strategic and operational planning. This has led to redundancies in GHE activities. The UN OCHA during its anticipated World Humanitarian Summit in May, 2016 should address this issue and identify best practices of performance measurements that may be consolidated into a unified strategy for HA and GHE activity evaluation.

IX. Conclusion

"We don't see things as they are, we see them as we are."
Anais Nin

Promoting and sustaining medical diplomacy partnerships through constructive and balanced engagements is a prerequisite for future global stability and must be predicated upon the need of the benefactor rather than the self-interest of the donor. Nonetheless, improving the execution and harmonization of GHS agenda activities through GHE between and within governmental agencies, public and private organizations, and foreign governments, will continue to be a challenge for the foreseeable future. Although demonstrating value during fiscal austerity may be burdensome, recent revolutionary changes in US agency collaborative organizational strategies, as well as renewed fervor for transparency is creating strident efficiencies in both national and international health diplomacy and security activities. To continue reducing fragmented approaches to US assistance, DOD, State, and USAID must evolve and be prepared to embrace further organizational consolidations, as well as the standardization of communications related to providing Humanitarian Assistance. Considering that governmental coffers will remain anemic in the near term, public and private organizations performing GHE activities in support of BPC and GHS agendas must improve the management and examination of providing Humanitarian Assistance in Phase 0 and Phase IV operations. Since medical diplomacy, whether minimal or large-scale, is never conducted in isolation, it is imperative that future engagement programs and projects not only be sustainable, but also tied to the long term development and security goals of beneficiary foreign nations in accordance with and/or support of United Nations Humanitarian Assistance protocols.

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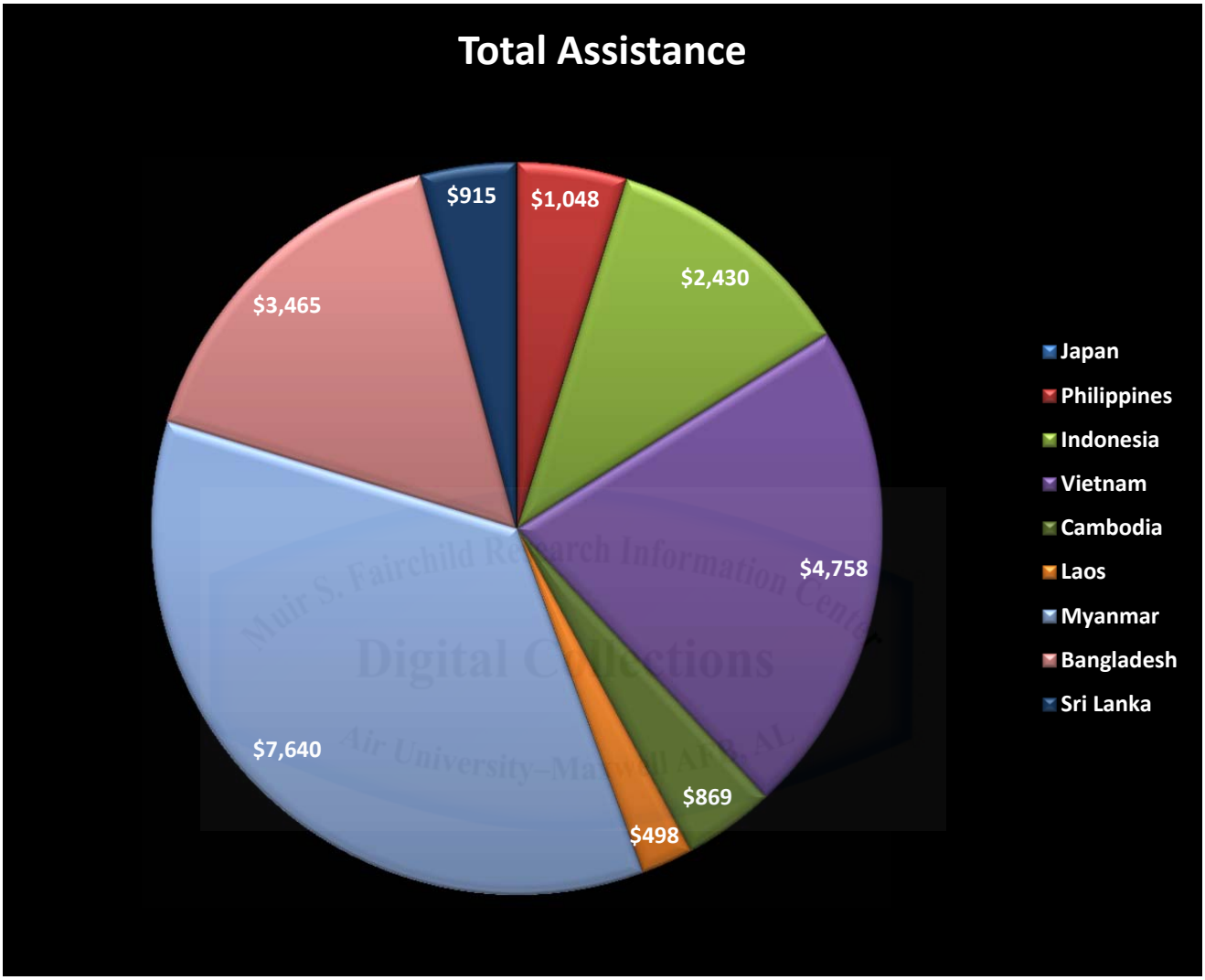
Appendix A. 2013 Global Humanitarian Assistance Budget

US$ Million

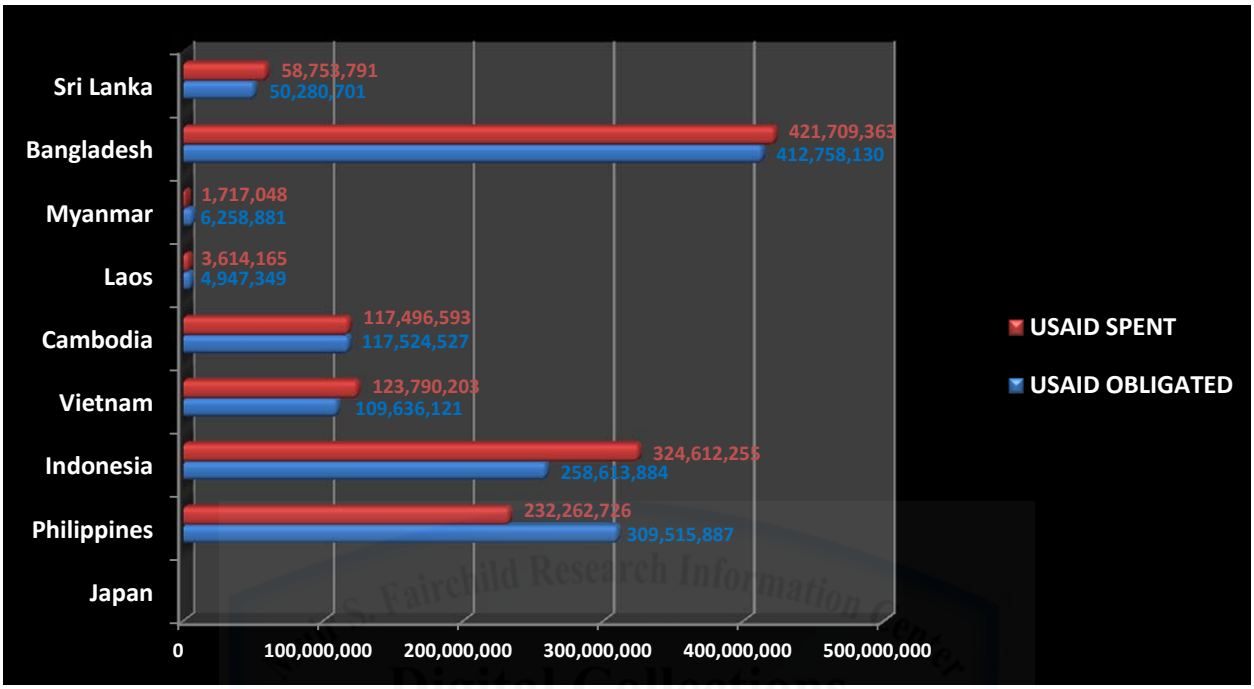


***Japan – data unreported**

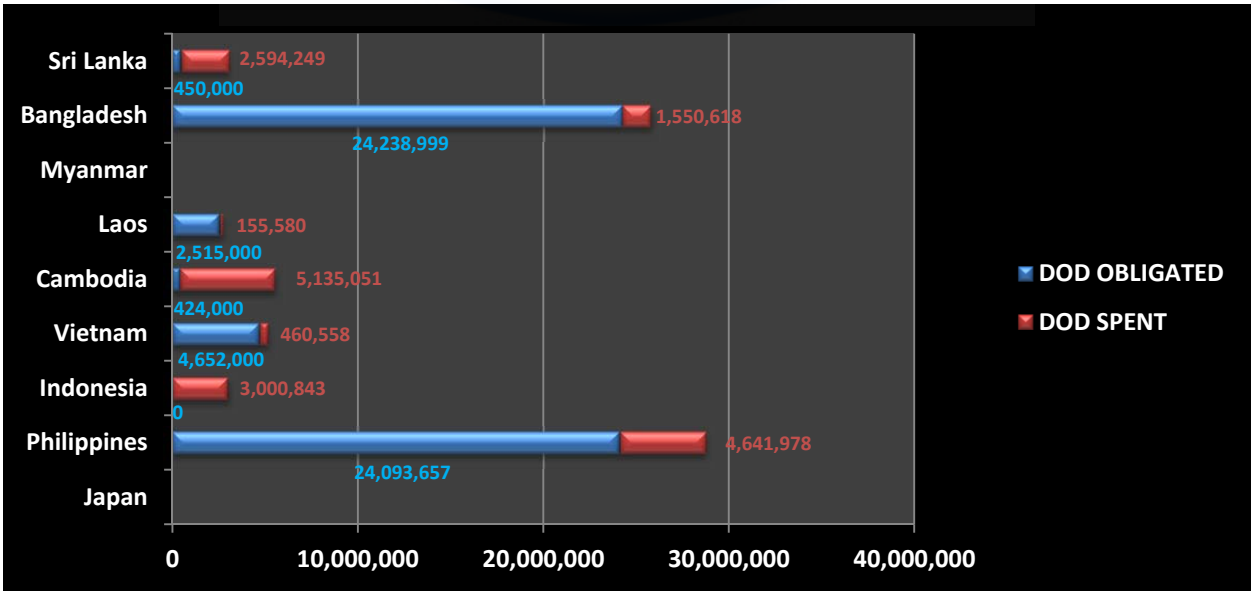
Appendix B. 2011 – 2013 USAID/DoD Total HE Appropriations

US$ Million

USAID Total Appropriations



DoD Total HE Appropriations

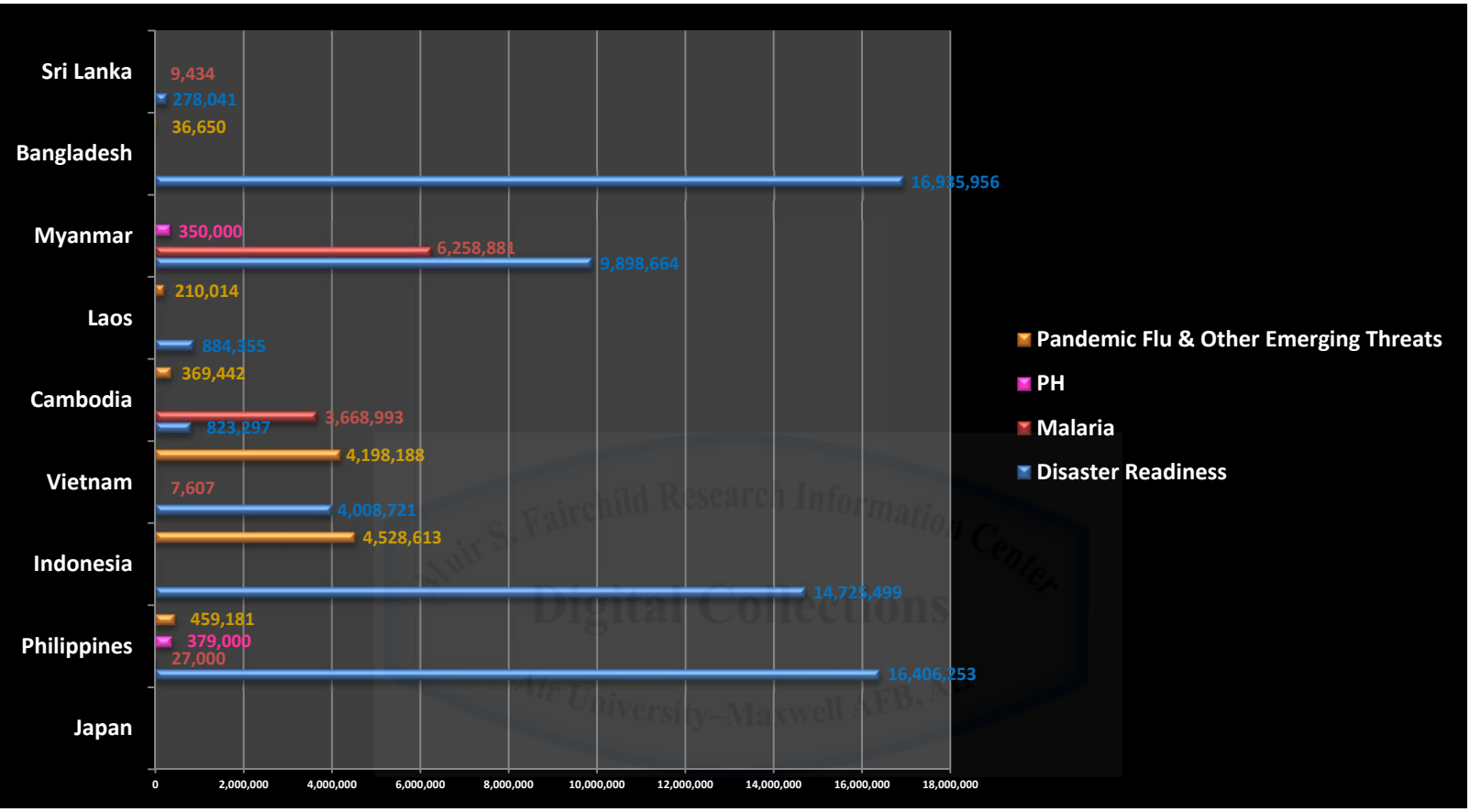


***Japan – data unreported**

Appendix C. 2011 – 2013 USAID/DoD HE Appropriations (By Sector)

US$ Million

USAID Appropriations by Sectors

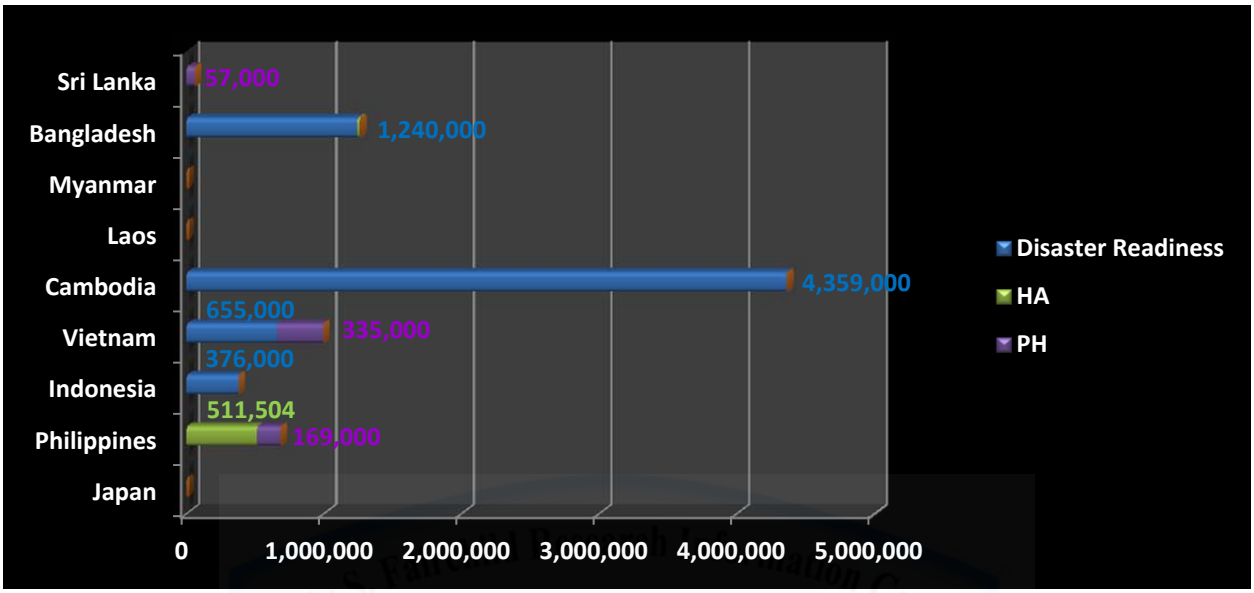


***Japan – data unreported**

Appendix C. 2011 – 2013 USAID/DoD HE Appropriations (By Sector)

US$ Million

DoD HE Appropriations by Sectors

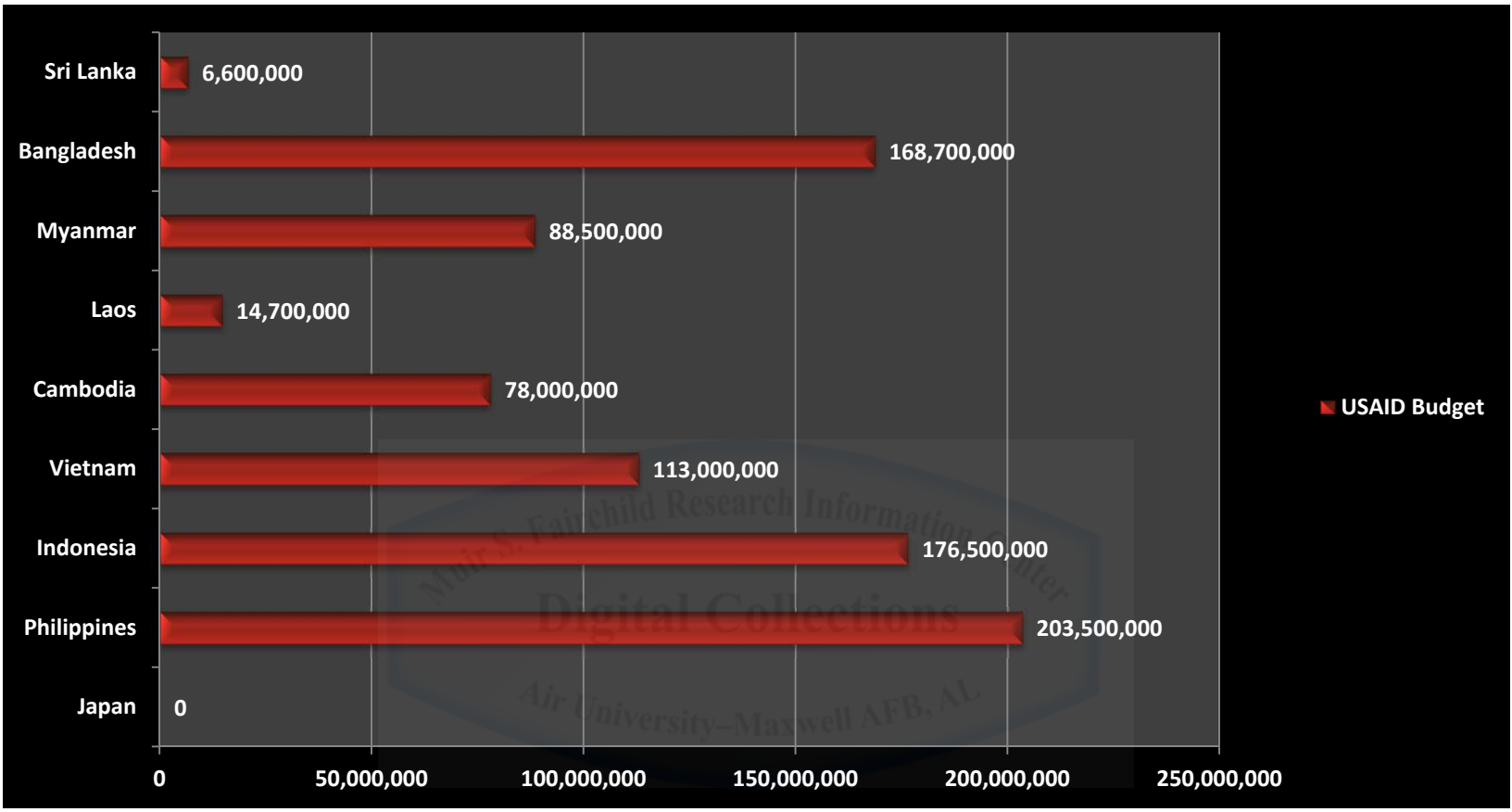


*** Myanmar (Burma), Laos and Japan – data unreported**

Appendix D. FY2015 USAID/DoD HA Budgets

US$ Million

USAID/OFDA

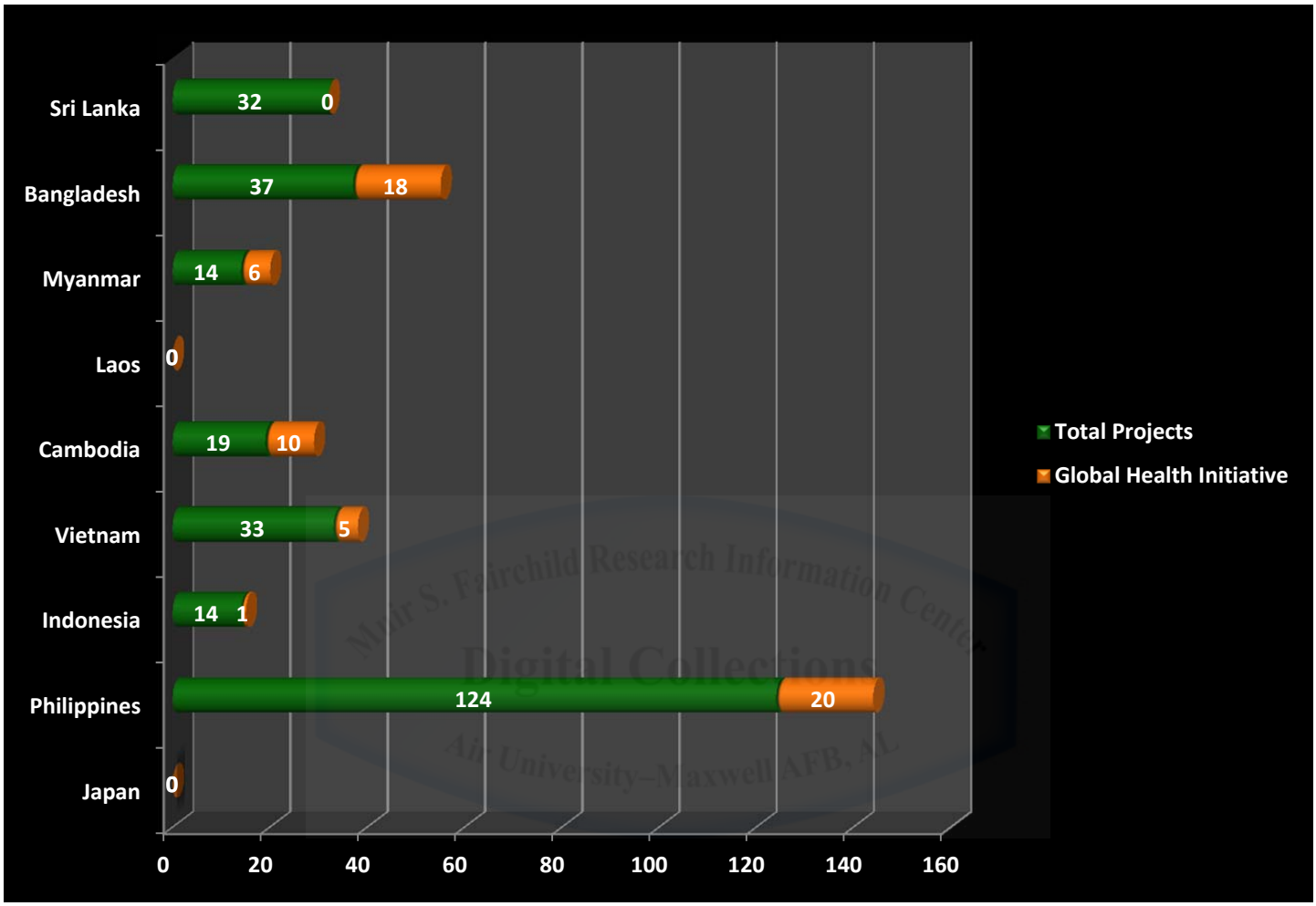


***Japan – data unreported**

DoD/OHDCA

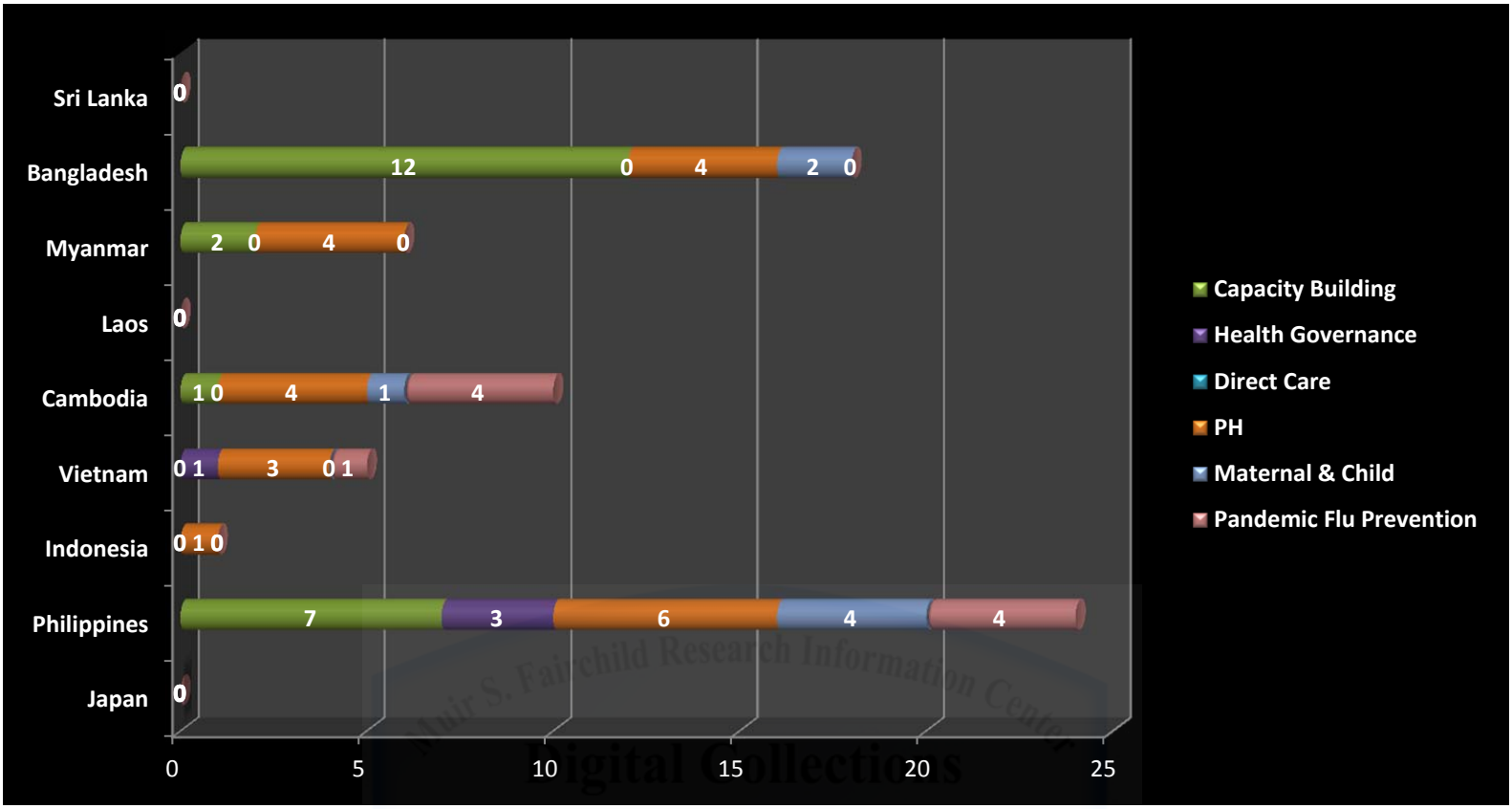
FY 2015 DoD Overseas Humanitarian, Disaster Assistance, and Civic Aid (OHDCA) Budget US$ Million	
2015	
TOTAL	100
PACOM	41.2
PROGRAM	TOTAL
Humanitarian Mine Action	5.841
Foreign Disaster Relief	15
Humanitarian Assistance	79.159

Appendix E. 2000 – 2013 USAID/OFDA FA/GHI Projects



***Japan and Laos – data unreported**

Appendix F. 2000 – 2013 USAID/OFDA GHI Projects (By Sector)



***Sri Lanka, Laos and Japan – data unreported**

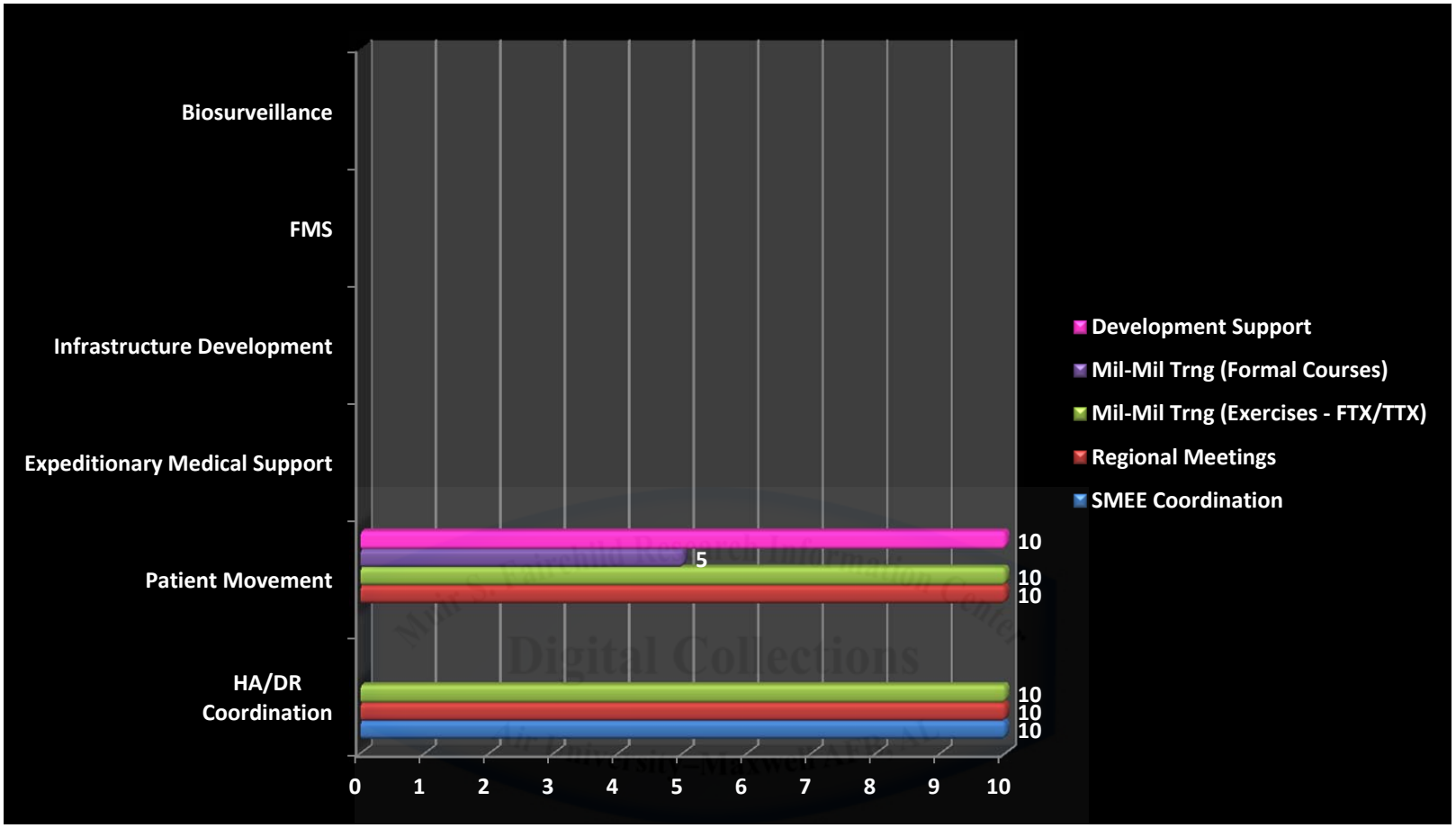
Appendix G. 2013 – 2014 PACOM GHE Supported Activities

2013 - 2014 PACOM Supported Activities				
2013 - 2014	Capacity Building	Health Governance	Trainings and Exercises	Disaster Response Exercises & Exchanges
Japan		●	●	
Philippines	●		●	
Indonesia	●		●	
Vietnam	●	●	●	
Cambodia	●		●	
Laos	●	●		
Myanmar				
Bangladesh	●	●	●	●
Sri Lanka			●	

***Myanmar (Burma) – data unreported**

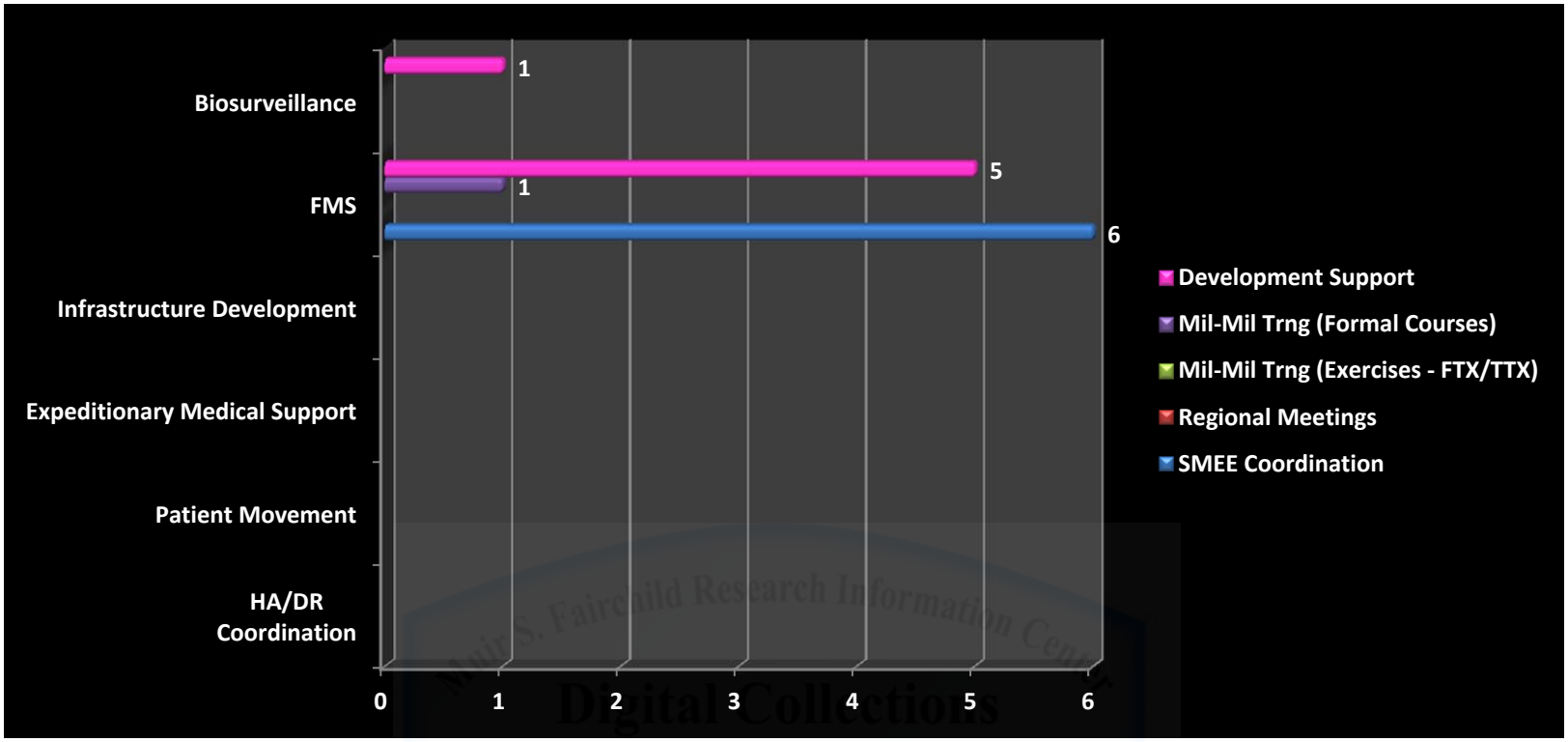
Appendix H. 2014 – 2019 PACAF GHE Supported Activities and LOEs

Japan

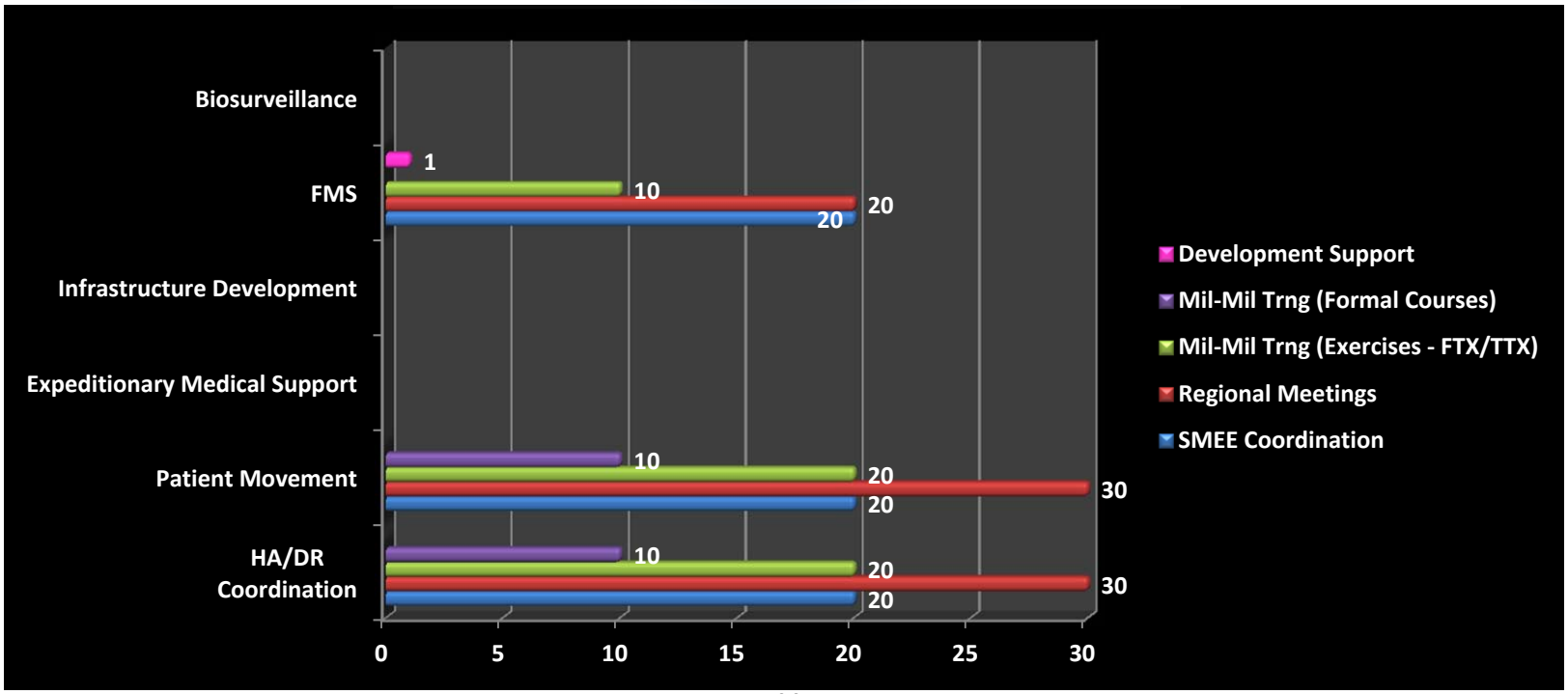


Appendix H. 2014 – 2019 PACAF GHE Supported Activities and LOEs

Laos

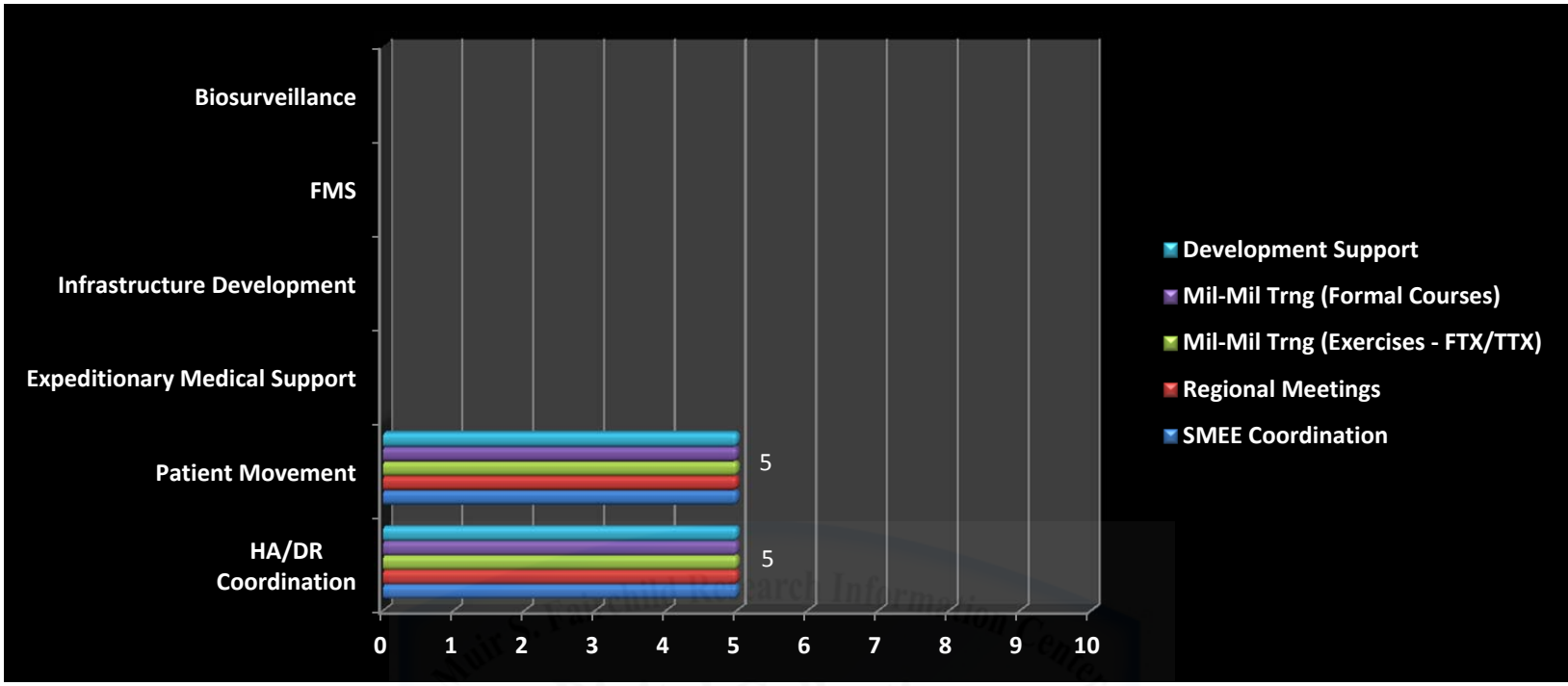


Philippines

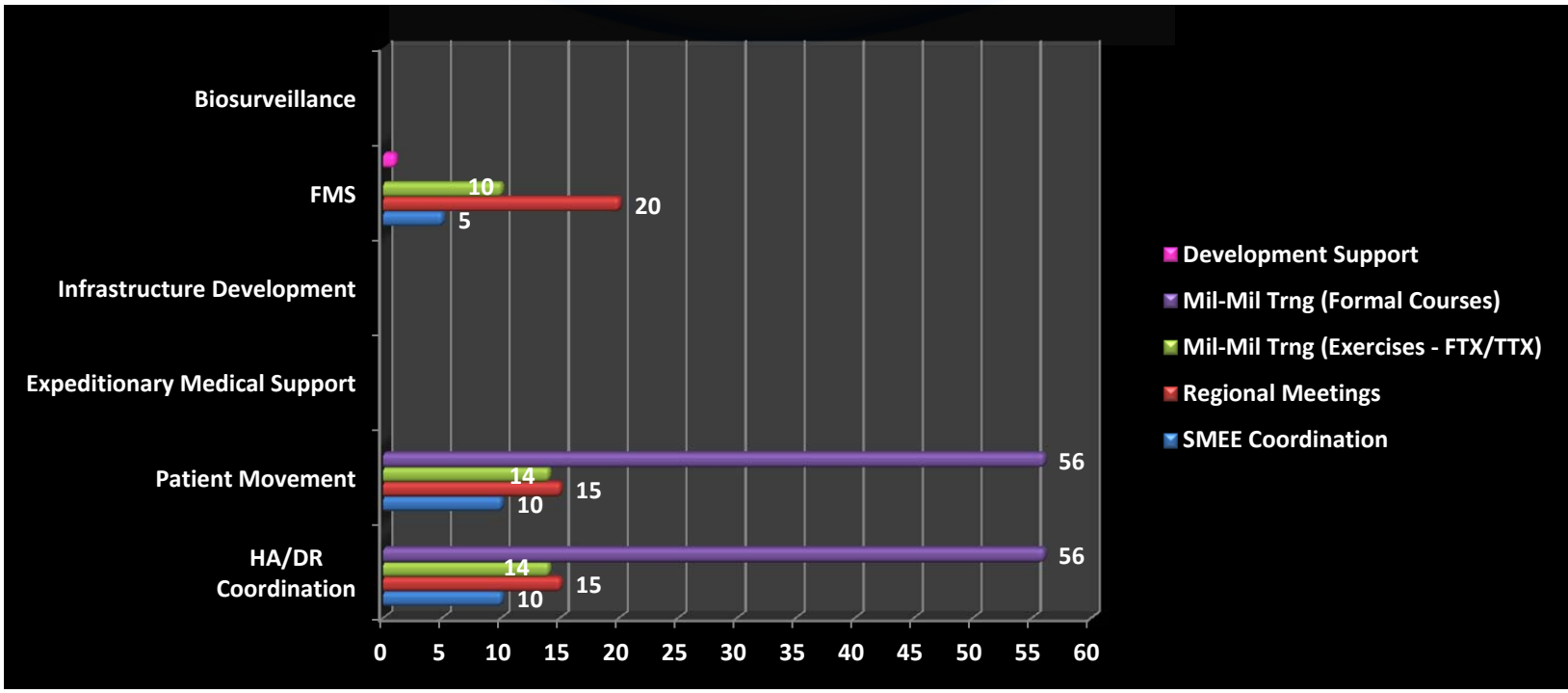


Appendix H. 2014 – 2019 PACAF GHE Supported Activities and LOEs

Sri Lanka

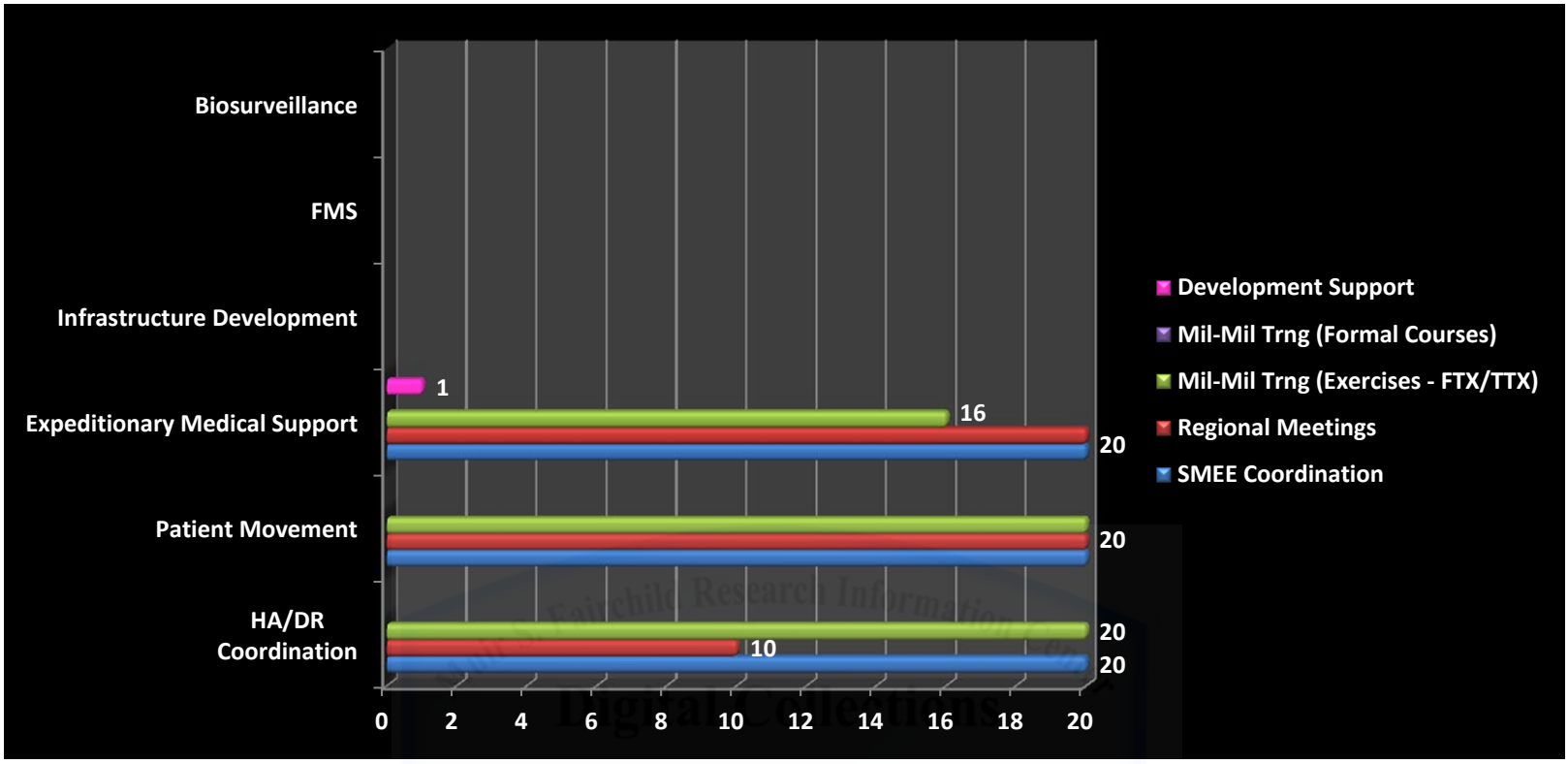


Vietnam

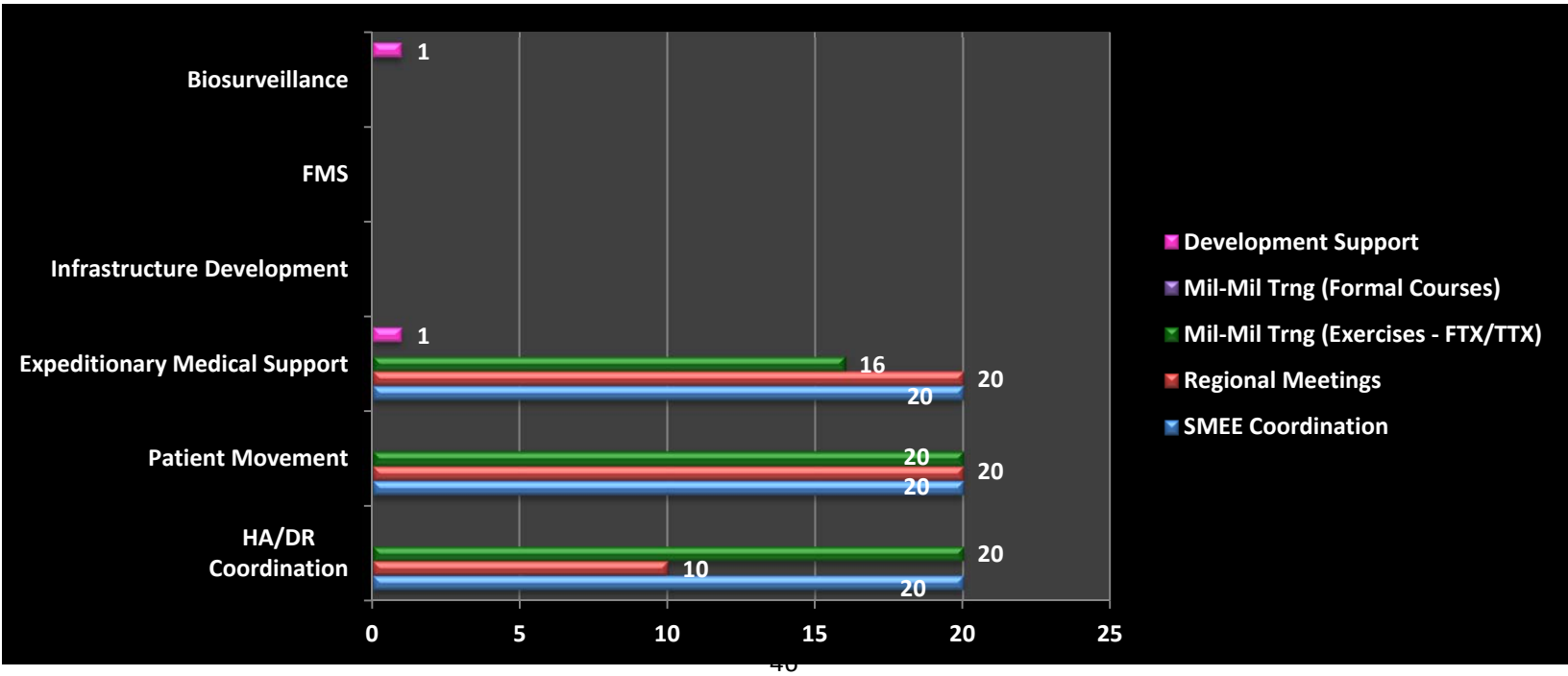


Appendix H. 2014 – 2019 PACAF GHE Supported Activities and LOEs

Myanmar (Burma)

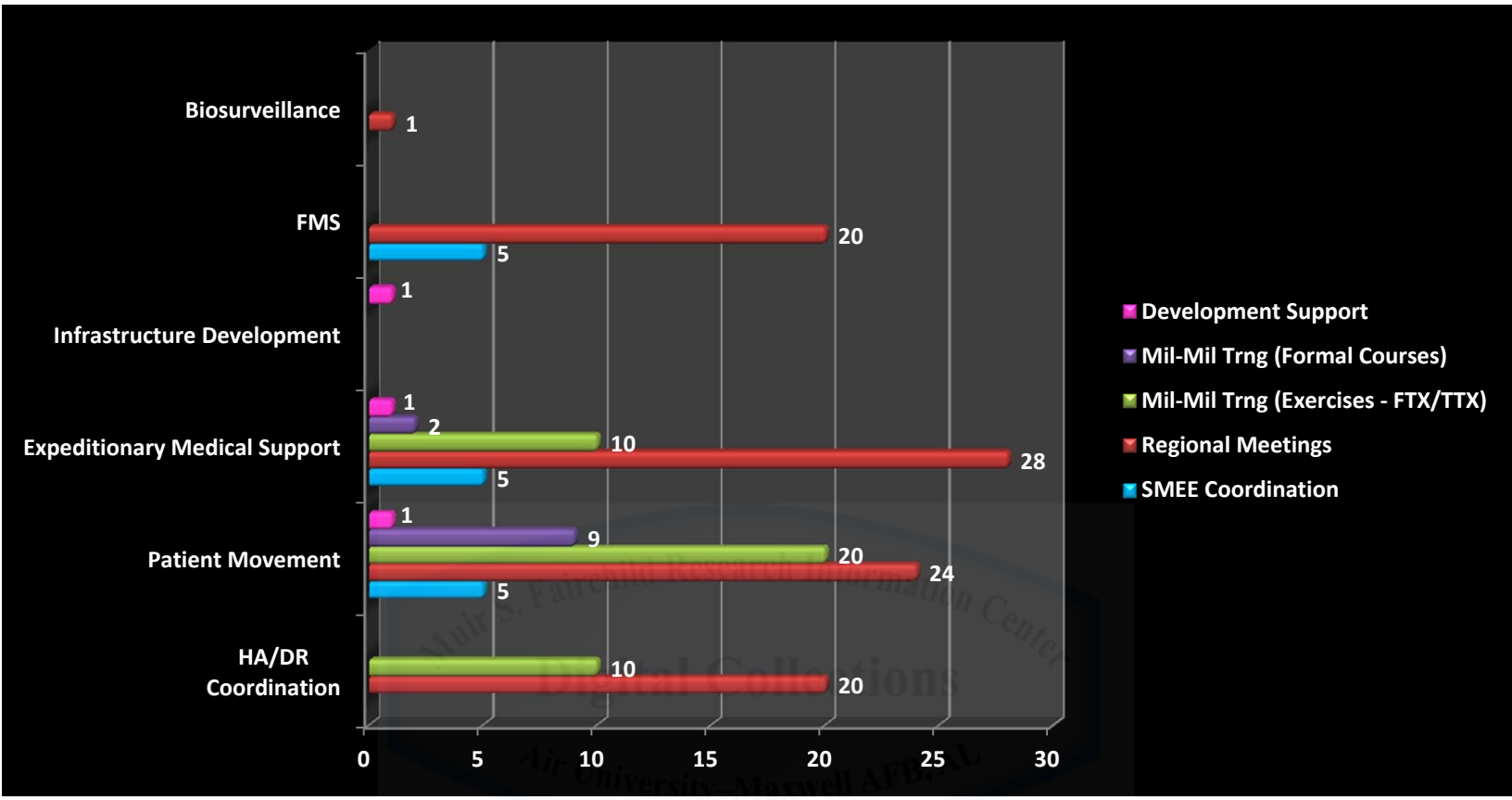


Bangladesh



Appendix H. 2014 – 2019 PACAF GHE Supported Activities and LOEs

Indonesia



***Cambodia – data unreported**

Appendix I. Literature Review Recommendations

N = 58

Literature Review Recommendations	
2000-2013	
Roles and Responsibilities	
Unified Strategic Vision	58
Establish/Codify End State Strategies between US Military - Civilian Operations	58
Organizational Structure	
Unified Organization	58
Improve/Streamline Communication	58
Expand US Military - Military Partnerships	23
Standardize Performance Measures	
MOE Standardization	58
Education and Training	
NGO/HN/Military - Civilian Joint Education and Training	32
Broker HN Military HN Military/Civilian Partnerships	14
Professional Military Education	8

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